House Study Bill 650 - Introduced

HOUSE FILE _____
BY (PROPOSED COMMITTEE
ON COMMERCE BILL BY
CHAIRPERSON LUNDGREN)

A BILL FOR

An Act relating to reimbursement for health care services provided after receipt of a prior authorization, and including applicability provisions.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. NEW SECTION. **514F.8 Preauthorizations — reimbursement.**

1. For purposes of this section:

a. "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

b. "Facility" means the same as defined in section 514J.102.

c. "Health benefit plan" means the same as defined in section 514J.102.

d. "Health care professional" means the same as defined in section 514J.102.

e. "Health care provider" means a health care professional or a facility.

f. "Health care services" means services provided by a health care provider for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease. *"Health care services"* includes dental care services, pharmaceutical products or services, and the provision of durable medical equipment.

g. "Health carrier" means the same as defined in section 514J.102.

h. "Prior authorization" means a determination by a utilization review organization that a specific health care service proposed by a health care provider for a covered person is medically necessary or medically appropriate, and the determination is made prior to the provision of the health care service to the covered person, and, if applicable, includes a utilization review organization's requirement that a covered person or a health care provider notify the utilization review organization prior to receiving or providing a specific health care service.

i. "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy, or efficiency of, health care services. Techniques may include but are not limited to

case management, preadmission review, pretreatment review, and prior authorization.

j. "Utilization review organization" means an entity that performs utilization review, including a health carrier that meets the requirements established for accreditation set by the utilization review accreditation commission or the national committee on quality assurance and that performs utilization review for the health carrier's health benefit plans.

2. *a.* A utilization review organization shall not revoke, or impose a limitation, condition, or restriction on, a prior authorization after the date on which a health care provider provides a health care service to a covered person per the prior authorization.

b. A health carrier shall reimburse a health care provider at the contracted reimbursement rate for a health care service provided by the health care provider to a covered person per a prior authorization.

3. A prior authorization for a specific health care service for a covered person shall be valid for the specific health care service for not less than one year from the date that the covered person's health care provider receives the prior authorization from a utilization review organization.

4. The commissioner may adopt rules pursuant to chapter 17A as necessary to administer this chapter.

Sec. 2. APPLICABILITY. This Act applies January 1, 2023, to health benefit plans that are delivered, issued for delivery, continued, or renewed in this state on or after that date.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill is related to reimbursement for health care services provided after receipt of a prior authorization.

The bill prohibits a utilization review organization from revoking, or imposing a limitation, condition, or restriction on a prior authorization after the date on which a health care

provider provides a health care service to a covered person per the prior authorization. The bill requires a health carrier to reimburse a health care provider at the contracted reimbursement rate for a health care service provided by the provider to a covered person per a prior authorization. "Covered person", "health benefit plan", "health care provider", "health care services", "health carrier", "prior authorization", "utilization review", and "utilization review organization" are defined in the bill.

The bill provides that a prior authorization for a specific health care service for a specific covered person shall be valid for not less than one year from the date that the covered person's health care provider receives the prior authorization from a utilization review organization.

The commissioner of insurance may adopt rules as necessary to administer the bill.

The bill applies to health benefit plans that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2023.